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Strange bedfellows? Setting up a systemic couples service in a sexual health setting.

Catherine Butler, Camden PCT

This paper describes the challenges and opportunities involved in setting up a systemic couples clinic in a medical setting, with increasing pressures to justify the use of psychologist's time.

Sex often, although not always, involves more than one person, yet sexual health clinics are set up for individuals. Even when couples arrive together, they are processed separately, often with separate male and female waiting rooms. Referrals to psychology within such settings also tend to be individually focused, with space for one name on the referral form and individual clinic numbers for data collection. Within this context, a systemic couples service was created.

Experience has taught me that interventions concerning sex are most effective if both partners attend. Setting the referred client 'homework' to do with their partner between sessions (which evidence concludes brings desired change, e.g. Segraves & Althof, 1998) can be difficult when introduced by the 'client'. It may be constrained by power differentials within the relationship that might have contributed to the sexual problem in the first place. It also positions the 'client' as the person with the problem, when actually the sex is going wrong for both people. A circular pattern can be established where problems in the relationship contribute to sexual difficulties, and then the sexual difficulties themselves create and/or add to relationship distress (Hawton, 1995).

Couple therapy would therefore seem the obvious choice when working with problems to do with sex. Using systemic therapy for couples has a growing evidence-base, summarised in a meta-analysis by Shadish and Baldwin (2003). They found systemic therapy proved more effective than waiting list controls and as efficacious, and at times better, than individual therapy. Butler and Byrne (2007) highlight the use of systemic therapy in working with sexual issues, as it explicitly explores power in relationships, which is particularly pertinent when it comes to gender relations, working with lesbian and gay clients or working cross-culturally, especially about a topic that carries moral judgements and the potential for stigma and discrimination.

The context of my service also lent itself to using a systemic approach. I completed my systemic psychotherapy training after qualifying as a clinical psychologist. Our team of five psychologists work in a trust with excellent in-house training, which includes foundation courses in systemic therapy (accredited by the Association of Family Therapy). All psychology team members have completed this course and were keen to develop these skills as continued professional development (CDP). It was felt that this, coupled with the evidence from client work, presented a strong case for starting a systemic clinic.

The process

Pilot Stage

The psychology team used systemic approaches as one of a range of models in individual work, and offered couple work depending on the therapists' level of confidence. Working with a colleague in the room as a systemic team member therefore felt like a shift. This process started as 'pairwork', where a colleague and I alternated being the lead therapist or systemic team member for 4 cases (two couples and two individuals), each offered six sessions. In supervision we reflected on how we worked together, as I was more qualified systemically, but my colleague was three years more qualified as a psychologist. This brought up anxieties in both of us about being observed in our clinical work. The sessions went well, but we felt using the multiple perspectives that pairwork brought worked better with couples than individuals. We were mindful to openly share differences in options in reflecting conversations (Andersen, 1987) so that we did not present a 'united ideal couple', particularly being a man and woman pairworking with gay male clients. Any hint of an expert stance could have fallen into heteronormality and so we used the differences between us, in terms of gender and ethnicity, and our differences with the clients, in terms of sexuality, as curiosities (Cecchin, 1987) in our reflections and questions.

Setting up the systemic clinic and referral pathways

Expanding the work to include other psychology team members brought a number of unique challenges and opportunities. A formal process of referrals to 'the systemic clinic' needed to be developed. The MDT referred individuals (or couples, albeit rarely) to the psychology team and a general psychology assessment was given. If the assessing psychologist judged couple therapy to be most beneficial at that time, and the client was agreeable, the psychologist then made a referral to the systemic clinic. This required a new referral form in order to collect their partner's contact details and demographic data. Referrals to the systemic clinic were given a slot in the weekly psychology meeting and a lead therapist allocated.

The allocated lead therapist phoned each member of the couple to introduce themselves and discuss their 'relationship to help' (Reder & Fredman, 1996). Thus, rather than the point of contact being the originally referred client, this immediately set up the couple therapy as offered to both members of the couple. This was important, particularly in sero-discordant couples where only one person has HIV, as the clinic environment might be seen as the domain of the HIV positive client.

Each session lasted 2 hours and was conducted in a Milan format (Tomm, 1984) with 30 minutes each for the pre and post sessions and an hour for client contact. Clients were offered six sessions with a minimum of two weeks between sessions to give time for change to occur.

Challenges

Working in a health context

Sexual health services operate within the context of diagnosis and medical treatments. Often psychology sits within this as an ancillary to the medical team, rather than as an integrated part of the multidisciplinary team (MDT). The language and approach of systemic therapy might appear to clash and contradict the medical model adopted by the MDT (made up of doctors, nurses and health advisors). However, contrary to this, we found a way of making this work. Two things contributed to this, firstly, the expert-patient approach (DoH, 2001) adopted in chronic health conditions, meant that

clients were accustomed to staff encouraging them to use their own language to describe what was happening. Secondly, the medical language and explanations that clients arrived with were treated as other hypotheses that might or might not be helpful, and given equal weight to the couple's own hypotheses and those the systemic team came up with. We also found that feeding back progress to our medical colleagues using appreciative language, taken from the therapy, often gave new perspectives on the client's situation and resourcefulness.

Use of psychologists' time

With increasing pressures from commissioners to increase the through-put of clients and increased scrutiny on the use of our time, justifying allocating more than one psychologist to a case was needed. A limit was set on how many systemic team members could work with each client. As the person providing live supervision from behind the one-way screen, I was present in all systemic teams; this time recorded as providing supervision. One other systemic team member was allocated from within the psychology team. Their time was initially viewed as CPD, but this raised the issues of how much CPD time would be taken up by the systemic clinic, thus limiting opportunities for psychologists attending other courses and increasing pressure on other clinical time. My manager and I therefore agreed to include this time within individual clinical targets.

Paper work and data entry

To fit within the wider context of 'Payment by Results' we needed to record this activity to reflect as accurately as possible the psychology time involved. This meant the partner of the referred client had to register with the clinic on their first visit to be allocated a clinic number. The lead therapist entered the referred client in their activity data and the systemic team member entered the partner in their activity data. Another problem that arose was co-ordinating diaries to see clients, with members of the psychology team working on different sites on different days, and so a set time was allocated to run two client sessions on a Tuesday morning. The lead therapist was in charge of all paperwork in relation to that client and co-ordinating appointments. A central appointments diary was created online so that appointments could be booked from either site where psychology team members were based.

Introducing the idea to the MDT

As with being accountable to our commissioners, the main challenge in introducing the clinic to the MDT was how to justify "so many" psychologists giving their time to one case. We began by seeing couples when appropriate, rather than 'launch' a new service. This bottom-up way of introducing the practice meant we could establish a system of working before presenting it to the MDT. Members of the MDT began to notice that increased numbers of psychologists were gathering on Tuesday mornings and people became curious about this. When we presented the clinic, the MDT were therefore already interested and open to the ideas. The presentation was heavily slanted towards presenting the 'evidence-base' of this approach, to fit with the medical language used by the health care professionals in the audience. We introduced the usefulness of the clinic for CPD and to be transparent about our work with each other and the MDT, and invited people to join as observers.

Opportunities

Involving MDT members

MDT members were invited to attend to either observe the way therapy was conducted or to observe a session with a client they were involved in or had referred. No one chose to use the clinic for the latter reason, and this might be because of MDT working patterns making attendance at the allocated time problematic. However, there was interest from SHOs to attend to learn more about what psychology did. The clinic was also attended by psychosexual counsellors from a related service (contraceptive services) who wanted to get ideas for their work and develop skills, such as working with interpreters. We had good feedback from all those who attended that the observation had been useful.

CPD

The clinic provided CPD for the psychology team to expand on systemic teaching and make theory-practice links come alive. In addition, we were visited by psychologists from other services within the trust as part of the trust's in-house training for an intermediate systemic qualification. We were able to provide an experience of witnessing systemic therapy in an adult health context, which could not be gained elsewhere in the trust. In addition, pairwork became a model of working used widely in the psychology team to increase confidence of working with couples and for complex cases.

Trainees

As with psychologists' CPD, the clinic also provided an excellent resource for trainees to be part of reflecting teams and observe their supervisor and other psychologists carry out systemic therapy. This also allowed us to offer a specialist systemic placement, which is rare in health settings (most privileging CBT).

Outcome

Clients' comments

A questionnaire and consent form was sent with reply envelopes to each member of the couple. Five out of ten questionnaires were returned. All clients found the therapy either "very" or "a little" helpful and all thought that other people had noticed improvements in the presenting problem. All clients commented that they found the reflecting team conversations particularly useful, for example, "it was amazing how they picked up on my thoughts and noted things you didn't even acknowledge". One person shared their appreciation of how the "discussions were led and controlled by the therapist to allow openness and frankness". Using a rating scale of 1 to 10 (with 10 being the best things could be and 1 being the worse) all clients reported an improvement from the start to the end of therapy (from an average of 4.6 to an average of 8.2), however, some people had seen a return of the influence of the problem when rating the same issue at the time of the questionnaire (an average of 5.8), although it was still an improvement from when they started therapy.

Team members' comments

Systemic team members were emailed for their thoughts about the clinic. Members felt that as a result of attending the clinic they were more confident working with couples, as well as in their use of systemic theory and practice. They valued the opportunity to work together and have support from colleagues. As predicted, the problems listed were the logistics of working on different sites making it difficult to contact clients between sessions if the paperwork was elsewhere, as well as sometimes having long gaps between sessions because of trying to co-ordinate all

team members' diaries. Since starting the clinic and presenting it to the MDT there has been an increase in referrals for couples to the psychology team.

Future possibilities

It is hoped that the systemic clinic will continue to be supported and grow as a resource for clients, the psychology team and the MDT. Hopefully there will be interest and opportunities for more MDT involvement, including consultation for one-off sessions with complex cases or integration into MDT staff inductions to improve the profile of psychology, foster transparency in what we do and encourage referrals from new staff. Some of the frustrations of the systemic clinic around organisation could be avoided if the time was protected for the whole systemic team to attend, rather than just for allocated clients, therefore providing consistency. In addition, if the clinic was formally viewed as both CPD and clinical time, CPD opportunities could be further developed. For example, if there were DNAs the team could use audio/video tape to review previous sessions, or use role play to practice techniques or try out different hypotheses, or else discuss papers.

Conclusion

Within a medical sexual health context, a systemic clinic for couples filled a gap in service provision and offered a useful intervention to clients and staff. Building the clinic slowly allowed for adequate time to accommodate and plan for administration concerns and introduced an alternative way of offering psychology services to the MDT. The future opportunities that the clinic holds are exciting for clients, CPD and the psychology team and better connections with the MDT. Hopefully these benefits outweigh the constricting question of justification of having more than one psychologist assigned to a case.

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Address

catherine.butler@epsom-sthelier.nhs.uk